MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Horizon Ballroom
Ronald Reagan International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, November 7, 2002
10:28 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Workplan for assessing the adequacy of outpatient dialysis payments
-- Nancy Ray

MS. RAY: I am here to discuss outpatient dialysis payment issues and to present to you workplans for two studies. One is a new study and one is not a new study. We're looking for any questions or comments you may have on both of the workplan.

Just a brief refresher course about how Medicare pays for outpatient dialysis services, through a prospective payment called composite rate which was implemented by Medicare in 1983. It covers many of the services associated with outpatient dialysis including nursing, supplies, equipment, and specific laboratory tests. Most patients receive hemodialysis in facilities; roughly about 90 percent of all dialysis patients. In hemodialysis a machine cleans waste from the patient's blood. The other dialysis modality is peritoneal dialysis and in that case blood is cleaned using the lining of the patient's abdominal cavity that acts as a filter.

On average, facilities receive about $130 per dialysis treatment through the composite rate. Facilities are paid for furnishing up to three hemodialysis sessions. For home dialysis, which is often administered more frequently than three times per week, like peritoneal dialysis payment is generally equivalent to -- the weekly payment for peritoneal dialysis is equivalent to three hemodialysis sessions per week.

Notably, the composite rate payment bundle does not include certain injectable drugs and these drugs are separately billable. These drugs were generally not available when the composite rate was implemented 1983. These drugs include erythropoietin that's used for the treatment of anemia, and the payment rate for that service is set by the Congress. Other separately billable drugs are paid 95 percent of average wholesale price.

Just a little bit more background to put outpatient dialysis in prospective. In the year 2000, for freestanding facilities -- and again, that represents about 80 percent of all facilities, Medicare spent roughly $3 billion for composite rate services and they spent about $1.8 billion for injectable drugs. I apologize for the different years for this data by I tried to give you the most recent that I have.

In 2001, there were roughly 280,000 dialysis patients and about 3,900 dialysis facilities. Like I said to your previously, the average composite rate payment in 2002 was roughly $130.

Finally, ESRD patients receive all Medicare covered services so their total spending is roughly about $14 billion. Again, that includes all services, not just dialysis. That includes physician spending, hospital spending, post-acute spending.

MS. BURKE: Can I just ask a factual question on this? I just wasn't sure I understood. I just want to walk back through the numbers you just utilized. Estimated spending for freestanding, which is 80 percent of the dialysis that occurs is essentially $4.8 billion. That's just for dialysis, setting aside their other services. The 282,000 dialysis patients in '01 are the patients using these freestanding or the totality?

MS. RAY: That's actually totality.

MS. BURKE: If you were to give me the total number for dialysis services what would it be?

MS. RAY: Dollars?

MS. BURKE: Yes.

MS. RAY: It's roughly about $14 billion.

MS. BURKE: No, for the non-freestanding. For the other dialysis -- this is the 80 percent?

MS. RAY: Right.

MS. BURKE: This is 80 percent for dialysis or 80 percent of the total cost of these patients for all services?

MS. RAY: The estimated spending numbers, the $3 billion for dialysis and the $1.8 billion four injectable drugs, those are based on claims submitted by freestanding dialysis facilities.

MS. DePARLE: How about the hospitals?

MS. RAY: I haven't gone through the same data exercise for hospital-based. I can come back and give you that exact figure at the next meeting.

MS. BURKE: So the 282,000 patients are a greater number than essentially is reflected by the 4.8?

MS. RAY: The 282,000 patients include those treated at freestanding facilities as well as hospital-based facilities, that is correct.

MS. BURKE: So if it's about, in our gross calculations here, about $20,000 per patient, that's actually not accurate because the --

MS. RAY: No. But I will come back at the next meeting and give you more complete information.

MS. BURKE: That's fine. I just wanted to make sure I understood these numbers.

DR. ROWE: May I also ask a -- do you know what the number is for the total expenditures for the patients? Not just the $14 billion for the dialysis treatments but the total expenditures.

MS. RAY: The $14 billion is for all Medicare covered services.

DR. ROWE: How does of that is for dialysis?

MS. RAY: Again, I apologize for not having my numbers consistent because, again, that number is for both freestanding and hospital-based. I'll come back to you in December and --

DR. ROWE: It doesn't matter to me. In other words, I'm just trying to figure out, of the total health care expenditures of somebody with end-stage renal disease what proportion is for dialysis, whether it's in a hospital, freestanding --

MS. BURKE: A little under $6 billion.

DR. NEWHOUSE: The little under half. Somewhere in the 40 percent --

DR. ROWE: Which is very different than in the commercial population.

MS. RAPHAEL: What is it in the commercial population?

DR. REISCHAUER: He isn't allowed to say that till later. Chaos has reigned in your absence. They've gone out of control.

But now that you're in charge, I want to just ask you one thing.

[Laughter.]

DR. REISCHAUER: 282,000 patients, 3,900 dialysis facilities but some of them are going somewhere else. This means the average facility has less than 70 people? Pretty small, mom-and-pop --

DR. ROWE: But they show up three times a week.

MS. RAY: I can actually at the next Commission meeting bring you more information

about that. We can pull some data out from CMS's facility survey that reports patients and number of sessions provided.

I'm here today primarily to discuss two workplans. The first study is not new for the Commission. This study fulfills our statutory mandate to annually examine the adequacy of the composite rate and make a recommendation to the Congress about an update. This will be in our March 2003 report.

The second study is new and it's focused on examining the relationship between payments, costs, and quality of care. I will be discussing the workplan for the study in greater depth at the conclusion of my presentation.

Just to briefly review how we go about conducting our update analysis, the goal of the analysis is to make a recommendation about the composite rate payment for 2004. I will follow MedPAC's two-step approach that we use for other services in Medicare that we make an update for like hospitals, home health, and SNF. The first step is to assess whether Medicare's payment are too high or too low by estimating current payments and costs, and by assessing market conditions. If we think it is either too high or too low, our update recommendation could include an adjustment to the payment rate.

In the second step we try to predict the change in efficient provider's cost in the next payment year. Each part of the process can result in a percentage change. They are summed to determine the final update recommendation. Commissioners will be making the update recommendation at the January meeting and I will be presenting you data both in December and January.

I'd like to briefly outline the steps we use to estimate current payments and costs. I think it's most important to note that we include payments and cost for both composite rate services and separately billable drugs because the payments and costs of the services are important for dialysis facilities. MedPAC began to consider the payments and cost of separately billable drugs in its analysis two years ago.

Just to give you a frame of reference, in 2000 roughly 40 percent of dialysis facilities' payments were for separately billable drugs, and this share has increased in the short time that we've looked at this between 1997 to 2000. Hopefully we will have 2001 data to present you in December.

Two project costs for 2003 we will assume that providers' costs will grow at the same rate predicted by the dialysis marketbasket index. This assumption seems to be sound. In last year's analysis we looked at the growth of costs, providers' cost between 1997 and 2000 and found that was similar to the growth in MedPAC's dialysis marketbasket index.

Finally, to model payments for 2003, we'll do that to reflect current law and current law does not change the composite rate between 2002 to 2004.

MR. HACKBARTH: Nancy, I'm sorry I zoned out for a second I think. Could you just say again what you said about the assumption that costs will grow at the rate of he marketbasket? Is that a good assumption?

MS. RAY: We think that's a good assumption. We really have no other hard evidence to base that assumption on. Last year when I looked at the rate of growth of provider's cost that matched pretty closely the rate our marketbasket estimated.

We also look at the appropriateness of providers' costs and we will assess changes in providers' costs for composite rate services and injectable drugs between -- we'll extend the

period now and look at it from 1997 to 2001, and we'll go ahead this time around and compare these changes to the growth in MedPAC's dialysis marketbasket. To examine trends in product change we will look at measures of staffing, at dialysis treatments per station, at total treatment per employee, and information about the length of dialysis sessions between 1997 to 2001.

We will also consider broader measures to look at the market conditions providers face. We will assess trends in the entry and exit of providers between 1993 and 2001 using data from CMS' facility survey. When we do this we'll look at the composition of dialysis providers in terms of their profit status, affiliation, and where they were located, in rural versus urban areas. And we'll analyze the growth in the number of facilities, again, between the period of 1993 to 2001.

We will try to evaluate the characteristics of facilities that have opened during this time period and facilities that have closed during this time period. Of concern is whether facilities are not opening or are closing where a greater proportion of Medicare beneficiaries are treated.

We'll try to look at providers' capacity to furnish dialysis and we'll do that by examining changes in the total volume of dialysis treatments between 1993 to 2001. And we'll also look at changes in payments for separately billable medications between 1997 and 2001.

Staff will present evidence about beneficiaries' access to high-quality care. Throughout the year I monitor published literature for evidence of systematic problems for beneficiaries accessing care. I also speak to providers about this issue in great depth, and I will also go ahead and present updated clinical performance indicators on dialysis adequacy and anemia management that's annually collected and published by CMS.

Finally, we will look at providers' access to capital. Access to capital is necessary for dialysis providers to improve their equipment and to open new facilities to accommodate growth in the number of patients requiring dialysis. Staff propose to focus this analysis on the four national for-profit chains which account for more than half of all facilities. Information we propose examining include the growth in the number of their facilities, the number of patients they treat, their earnings, and their bond ratings.

In the second part of our update framework, we account for providers' costs changes in the next payment year. To estimate inflation and input prices we will probably use MedPAC's marketbasket for dialysis services which comprises components from price indices for hospitals, skilled nursing facilities, and home health agencies. CMS' report that's due to the Congress on broadening the payment bundle also has a dialysis marketbasket index in that report, but my understanding is that report is still being reviewed within the agency.

We'll also qualitatively assess the impact of other factors on providers' costs in the next payment year such as new medical advances, one-time factors, and productivity improvements. Again, throughout the year we monitor evidence that gets suggest that providers' costs are expected to change significantly due to any of these factors.

At this point I'd like to shift gears a little bit and talk about the second study. This is a new study that you're seeing and I guess I'd like to just briefly talk about the background and rationale for us doing this study. This study was motivated out of questions about what is going on really with the relationship between the decline in the payment rate, the increase in providers' costs, and therefore the slow decline in the payment to cost ratios throughout the '90s. But it the same time throughout the '90s, the improvement in quality of care.

I'd just like to review a couple old numbers with you that we published last year.

Payment to cost ratios for composite rate services and separately billable drugs declined from 1.09 in 1997 to 1.05 in 2000. By contrast, quality of care improved. The percent of patients receiving inadequate dialysis declined from 32 percent in 1990 to 20 percent in 1999.

This study was also motivated out of the commissioners' discussion at the retreat about what is an efficient provider. When you look at the characteristics -- and it was motivated out of interest to look at the characteristics of facilities that furnish high quality care. In our analysis we've noted there is variation in providers compost rate cost per treatment. We're interested to examine how quality of care is different or is the same for those facilities that use fewer resources compared with those facilities who use more resources. As has been noted in the literature, higher cost does not necessarily mean better quality.

Other folks have looked at some aspect of this issue, specifically quality of care and the characteristics of facilities but they haven't specifically included the association of Medicare's payments and providers' costs in their analysis so this is new work.

So like I said, we'd like to begin to explore this relationship to see if there is any link between payment cost and quality of care and this is our first step in doing so. We think that ESRD provides us with a unique opportunity to look at these variables because CMS collects information on quality of care because we have providers' cost reports and because we have been on Medicare's payments. Potentially we can learn, hopefully, a little bit about what we learn here to other provider groups.

This analysis will use data from the 1999 to 2001 provider cost reports and Part A and Part B claims. Providers' costs will be measured in two ways: composite rate services only, and then composite rate services and separately billable drugs. Quality of care furnished to dialysis patients will be assessed using a number of different processes and outcomes including adequacy of dialysis and outcomes of anemia management, risk of hospitalization, and rates of referral for kidney transplantation. We have contracted with Chris Hogan to help us run through the data and conduct the statistical analyses.

That concludes my presentation and I'd be happy to take any questions or comments.

DR. ROWE: I have one or two comments, Nancy. First of all, this is comprehensive and it's excellent. In my work I interact with big dialysis companies, as you know, a fair amount. We cover dialysis for, I think it's the first 30 months or so, before patients become Medicare eligible. And we pay a fair amount more than Medicare so there's a fair amount of interaction. Nancy, as all the commissioners I'm sure are aware, is very respected, if not feared, in the industry.

I don't know how much of a change this is but I think it's at least a mindset change. I would like to ask you, Nancy, as you go forward, if it's not too much work, to change your focus as you look at this. I believe that Medicare, the intention is for this to be the end-stage renal disease program, but it gets discussed and analyzed as if it is the dialysis program. I think that we need a broader focus on the entire experience of the patient who is the Medicare beneficiary.

Less than half of the expenditures go for the dialysis treatments, and that these individuals have a tremendous amount of comorbidity and they have a lot of hospitalizations and shunt problems and infections and a lot of other antibiotic use for peritoneal dialysis related infections; a lot of other stuff that happens to these patients that is not directly dialysis related. It seems to me that we should be looking at the patient's experience as the end-stage renal disease patient as supposed to the dialysis patient.

I can't specify for you exactly how that would change the result, but it seems to me to be

clinically a more appropriate view, and it's really what it's all about. Because it may be that we should spend more money on dialysis and that we would be then spending less money on hospitalizations, or infections, or some other complications, and the patients would be better off and the whole program to be saving money. So I just think looking at the dialysis piece without a more comprehensive view seems --

I have, as Nancy knows and most of you don't unfortunately, I have way back in my history the fact that I am a board certified nephrologist, so I did this for a little while a long time ago. In the absence of Ted Lewers that would be my suggestion.

DR. NEWHOUSE: Nancy, in terms of this slide, my sense is that one of the things that's influenced quality here is in fact CMS's effort to focus on quality of care and develop indicators for this part of the program. It's my sense anyway, although it's just a gut feeling is that that's had more to do with quality than anything that's gone on on the payment policy side, but I don't know how to test that. But I think it certainly has to be recognized that they have developed these quantitative measures, or they've started to use the quantitative measures in administering the program.

I have a second comment but you look like you want to respond to that.

The other comment really was how our prior recommendations here which I certainly thought were right on target have not gone anywhere at why that is. We basically said in the past, we should bundle the injectable drugs in and we should risk adjust for the characteristics of the patients. Nothing has happened, I think. You're going to tell me something has? That would be great.

But my question was, if nothing had happened, was this an issue with CMS, whether they disagreed with it or thought they couldn't administer it, or whether it was an issue with the Congress that didn't want to do it.

MS. RAY: CMS has prepared a study that looks into issues related to broadening the bundle. That study was to due to the Congress in July. My understanding is that it's still under review within the agency. So the progress has been made and I don't think our recommendation fell on deaf ears. So I think the next step is to wait for CMS's study and to review it once it's available to the public.

MR. HACKBARTH: Nancy, do you know if the draft that they're looking at goes beyond expanding the bundle to the risk adjustment piece that we've also recommended or is it just about the size of the bundle?

MS. RAY: I don't know. My sense is it's just broadening the bundle, but I wouldn't swear to that.

I'd like to go back to your issue about quality of care. I think that CMS's publishing the measures has had an impact. You still do see regional variations in quality of care however. But you're right, I think it has had some effect.

MS. BURKE: I checked back through because I didn't recall reading this last evening when I read it, and that is the issue of the difference in payment rates between freestanding and hospital-based facilities. When we did the amendments in '81 there was a fair amount of discussion at that time and the difference between the two. There had been a history of a series of issues, reuse and a variety of other things that had occurred.

In the document it was not clear to me as we look at this issue and this list of issues, whether the question of whether or not there continues to be a difference, other than the obvious

cost allocation issues which occur presumably in a hospital-based facility, but whether there is -- there is now a differential of $4 or some amount between the two rates. Whether there continues to be a basis upon which that difference is presumed to be made, whether that is an issue that ought to be rethought.

Now one of these questions is an acuity question. There had been for long period of time the presumption that the patients that were being served in hospital-based units had a higher acuity. I don't know whether that remains the case today, whether anyone has any idea whether there is a difference between the patients that are seen. A risk adjuster would deal with that issue irrespective of the location of the treatment.

But I wondered as we look at payment issues whether that issue has recurred, whether people have looked at whether or not there is a basis for the difference in the rate. It is something Congress got in the middle of historically, but I don't know whether or not any work had been done subsequently on what the difference ought to be, whether there ought to be one, and whether it ought to be something ultimately that's dealt with through risk adjustment or not. I didn't see in the discussion -- it's almost entirely based on the freestanding issue rather than the hospital-based. I wondered -- I mean, it's 20 percent, but its 20 percent.

MS. RAY: Right. The $4 difference has not been revisited by anybody since then.

MS. BURKE: Since '81?

MS. RAY: That's correct. I think at this point what we said two years ago when we made the recommendation for refining the payment design in the 2001 report where we made the recommendation for the broader bundle, at that time I didn't see any real studies showing differences in patient acuity between hospital-based and freestanding facilities. I didn't see any published evidence in peer review suggesting that there were significant differences.

MS. BURKE: So we assumed that the rationale for the $4 remains the rationale we had in 1981? I knew we were brilliant at the time, but I would have thought time would have passed even me by.

MS. RAY: What MedPAC's recommendation said in 2001 is that payments should be based on efficient providers' costs, and that payment should be adjusted for those factors that are known to affect cost. We did have evidence, for example, that providers' costs do differ based on the frequency of dialysis, based on the dose of dialysis, based on dialysis modality.

MS. BURKE: But does that differ between the location of service?

MS. RAY: No, I have not seen that those variables differ by the location of service. What we said specific to hospital-based and freestanding in the 2001 report is that's an issue that CMS needs to address when they're figuring out what the payment should be, to determine whether or not it still appropriate for there to be a difference between freestanding and hospital-based.

MS. BURKE: We don't know whether or not the current study will in fact address that issue?

MS. RAY: I don't know that.

MS. BURKE: So I guess I would just suggest as we go forward with this that at some point we ought to opine on the fact that someone ought to ask that question.

MR. HACKBARTH: Any other comments or questions?

MR. FEEZOR: Just to underscore Jack's observation about looking at the total program. I thought that was profound and we need to do that.

MR. HACKBARTH: All right. Thank you, Nancy.